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Supreme Court, U.S.
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No. 93-1907

In The

Supreme Court of the United States

October Term, 1994

DONNA E. SHALALA, SECRETARY OF HEALTH AND HUMAN SERVICES,

Petitioner,

v.

MOTHER FRANCES HOSPITAL OF TYLER, TEXAS,

Respondent.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Fifth Circuit

BRIEF FOR THE RESPONDENT IN OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Are 42 C.F.R. §§ 413.20(a) and 413.24 properly used to determine timing of reimbursement of costs that are admittedly reimbursable by Medicare?

2. Is PRM § 233 invalid because it constitutes a substantive rule that was not promulgated in accordance with the Administrative Procedure Act?

3. Is the decision of the Administrator invalid because it is not supported by substantial evidence as required by 5 U.S.C. § 706 and 42 U.S.C. § 1395oo(d)?

LIST OF PARTIES

Pursuant to Supreme Court Rules 15, 24, and 29, Respondent states that the following persons are parties to this case:

(1) Mother Frances Hospital of Tyler, Texas;

(2) Donna E. Shalala, in her official capacity as Secretary of Health and Human Services; and

(3) Bruce C. Vladeck in his official capacity as Administrator of the Health Care Financing Administration.

Mother Frances Hospital has no parent company or subsidiaries other than wholly owned subsidiaries. The Medicare fiscal intermediaries for Mother Frances Hospital, Blue Cross and Blue Shield of Texas, Inc. and Blue Cross and Blue Shield Association, are not parties but are acting as agents for the Secretary and may have an interest in the outcome of this case.

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STATUTORY AND REGULATORY PROVISIONS INVOLVED

42 C.F.R. § 413.9 Cost related to patient care

. . .

(b) Definitions – (1) Reasonable Cost. Reasonable cost of any services must be determined in accordance with regulations establishing the method or methods to be used, and the items to be included. The regulations in this part take into account both direct and indirect costs of providers of services. The objective is that under the methods of determining costs, the costs with respect to individuals covered by the program will not be borne by individuals not so covered, and the cost with respect to individuals not so covered will not be borne by the program. These regulations also provide for the making of suitable retroactive adjustments after the provider has submitted fiscal and statistical reports. The retroactive adjustment will represent the difference between the amount received by the provider during the year for covered services, from both Medicare and the beneficiaries and the amount determined in accordance with an accepted method of cost apportionment to be the actual cost of services furnished to beneficiaries during the year.

. . .

5 U.S.C. § 706. Scope of review

. . . The reviewing court shall –

. . .

(2) hold unlawful and set aside agency action, findings, and conclusions found to be –

(A) arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law;

. . .

(E) unsupported by substantial evidence in a case subject to sections 556 and

> 557 of this title or otherwise reviewed on the record of an agency hearing provided by statute;
>
> . . .

In making the foregoing determinations, the court shall review the whole record or those parts of it cited by a party. . . .

STATEMENT OF THE CASE

On May 31, 1994, Petitioner Donna E. Shalala, Secretary of the Department of Health and Human Services (the "Secretary") filed a Petition for a Writ of Certiorari in this case. The Petition, after the Statement, contained no detailed arguments as to why the Petition should be granted. Instead, it referenced the case of *Shalala v. Guernsey Memorial Hospital*, in which a Petition for a Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit was granted on April 4, 1994. Under the heading "Reasons for Granting the Petition" Petitioner stated:

> This case presents the same questions that are presented in *Shalala v. Guernsey Memorial Hospital, cert. granted*, 114 S.Ct. 1395 (1994) (No. 93-1251). The petition should therefore be held and disposed of as appropriate in light of the Court's disposition of *Guernsey Memorial Hospital*.

M. Fr. Pet. at 12. On June 30, 1994, Respondent Mother Frances Hospital of Tyler, Texas (the "Hospital") filed and served a letter pursuant to S. Ct. Rule 15.4, waiving its right to file an opposition to the Petition. By letter dated July 15, 1994, the Clerk of this Court advised counsel for the Hospital that although the Hospital had waived its right to file a response to the Petition, the Court had nevertheless directed the Clerk to request that a response be filed.

I. Comparison Of Issues In This Case And *Guernsey*.

As will be explained more fully below, two out of the three questions presented by the instant case are identical to the two questions presented in *Guernsey*. Those questions are the GAAP question and the rulemaking question (Nos. 1 and 2 in Questions Presented, above). A third issue in this case, not listed by the Secretary as a "Question Presented" in the Mother Frances Petition, is whether the decision of the Administrator is supported by substantial evidence, as required by the Administrative Procedure Act ("APA") and the Medicare statutes. This issue was pleaded and briefed in the *Mother Frances* case in the District Court and the Court of Appeals, and it is properly presented in connection with the Petition in this case. The "substantial evidence" question is not listed as one of the "questions presented" in the *Guernsey* case, although Mother Frances Hospital believes it is necessarily presented in the *Guernsey* case as well.[1]

If either the GAAP or rulemaking arguments were to be decided in favor of the Respondent hospital in *Guernsey*, the outcome in that case would control the outcome of the instant case. An adverse decision to the hospital in

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[1] 42 U.S.C. § 1395oo(d) requires that a decision of the PRRB "*shall* be based upon the record made at such hearing," and "*shall* be supported by substantial evidence when the record is viewed as a whole." (emphasis added) Judicial review of agency decisions in this context is made "pursuant to the applicable provisions under Chapter 7 of title 5," which include 5 U.S.C. § 706. *See* 42 U.S.C. § 1395oo(f). As set forth above, 5 U.S.C. § 706(2)(E) provides that an agency decision must be reversed if it is "unsupported by substantial evidence in a case . . . reviewed on the record of an agency hearing provided by statute."

Counsel for Mother Frances Hospital is informed that the substantial evidence issue was pleaded and discussed in the briefs in the *Guernsey* case in the lower federal courts.

Guernsey on both the GAAP and rulemaking arguments would control the decision of those two issues in this case.[2]

It is legally possible that a different result could be reached on the substantial evidence issues in the two cases. The substantial evidence issue is expressly listed as a "Question Presented" in this case (see above), and there are differences in the administrative records between the two cases. *See* discussion in "Reasons for Denying the Writ," Part III, below. However, the Hospital believes that in both cases the Administrator's decisions are not supported by substantial evidence.

Because of the identical GAAP and rulemaking issues in the *Guernsey* case and the instant case, and because the Hospital believes that the decisions of the Administrator in both cases are not supported by substantial evidence, the Hospital initially determined to waive its right to file a response to the Petition.

In the Hospital's view, a different result could be reached in *Guernsey* and *Mother Frances* only under the following circumstances, assuming that the *Mother Frances* case is held in abeyance during the pendency of *Guernsey* as requested by the Secretary.

- First, the Court would have to decide adversely to the hospital both of the two issues expressly presented by *Guernsey*.
- Second, the Court would either not reach the substantial evidence question in *Guernsey*, or would decide it based on the *Guernsey* record.

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[2] Throughout this discussion, the Hospital assumes that the issues in *Guernsey* will be decided on their merits, as opposed to being decided on some procedural ground. The Hospital is unaware of any procedural ground that would prevent the issues expressly presented in *Guernsey* and *Mother Frances* from being decided on their merits.

- Third, the Court would remand *Mother Frances* to consider whether the decision of the Administrator was supported by substantial evidence in the record.
- Fourth, on remand the lower court would conclude that a decision favorable to the Hospital would be reached in *Mother Frances* because the substantial evidence argument, which had not been considered by this Court in *Guernsey*, would be considered and would cause the Hospital to prevail; or, if this Court had considered the substantial evidence argument in *Guernsey*, the lower court would render a different decision than was rendered in *Guernsey* on grounds that the administrative records in the two cases justified differing outcomes.

Although this scenario is possible, the chance that precisely this outcome would occur was considered insufficiently likely that the decision was made to waive a response to the Petition.

Because the Court has requested a response, however, the Hospital will respond to the contentions of the Secretary in the *Mother Frances* Petition and the *Guernsey* Petition. The contentions specific to Mother Frances Hospital are contained in the "Statement" portion of the *Mother Frances* Petition. Therefore, those contentions will be responded to in the Statement of the Case herein.

The legal arguments raised by the Secretary are set forth only in the "Reasons for Granting the Writ" in the *Guernsey* Petition. Those arguments will therefore be addressed in "Reasons for Denying the Writ" in this Opposition.

In summary, although the Hospital recognizes that the Court has granted the Petition in the *Guernsey* case, the Hospital believes that certiorari should not be granted in the *Mother Frances* case. With the benefit of hindsight, having participated as an *amicus curiae* in the briefing in the *Guernsey* case, the Hospital also respectfully suggests

that certiorari may have been improvidently granted in *Guernsey*.

II. Disagreements With The "Statement" In The Petition.

The Hospital disagrees with several contentions by the Secretary in the "Statement" portion of the *Mother Frances* Petition. The Secretary states that the Medicare Act "authorizes the Secretary of Health and Human Services to promulgate regulations 'establishing the method or methods to be used'" for determining reasonable costs. M. Fr. Pet. at 5. The Medicare Act does not merely "authorize" the Secretary to issue regulations establishing such methods. The Act commands her to do so. The pertinent portion of 42 U.S.C. § 1395x(v)(1)(A) states:

> The *reasonable cost* of any services shall be the cost actually incurred . . . and *shall be determined in accordance with regulations establishing the method or methods to be used. . . . In prescribing the regulations* referred to in the preceding sentence, *the Secretary shall consider*, among other things, the principles generally applied by national organizations . . . in computing the amount of payment . . . to providers of services. . . . *Such regulations* may provide for [determination of costs according to different methods]. (emphasis added)

42 U.S.C. § 1395hh also imposes an obligation upon the Secretary to proceed by rulemaking in certain instances.[3] *See also* 42 C.F.R. § 413.9(b)(1) ("Reasonable cost of any services *must* be determined in accordance with *regulations* establishing the method or methods to be used . . . . "). (emphasis added)

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[3] 42 U.S.C. § 1395hh was amended after PRM § 233 was issued. *See* discussion in Amicus Br. of M. Fr. Hosp. at 7 n.2.

It is not true, as the Secretary states in her description of the 1983 bonds, that those bonds "bore interest at rates ranging from 8.6% to 9.5%, and were scheduled to reach maturity in 1998." M. Fr. Pet. at 6. $7,190,000 in serial bonds were due by 1998 at the interest rates cited by the Secretary. Admin. Rec. 1114. However, most of the bonds were term bonds. $19,365,000 in term bonds bore a rate of 9 3/4% and were due in the year 2007, and $25,780,000 in term bonds bore a rate of 10 1/8% and were due in 2013. *Id.*

Although the hospital estimated it would save $2,714,975 under the new bonds as compared to the old bonds, that estimate has little if any relevance to this case. M. Fr. Pet. at 7. The Secretary has consistently sought to imply that the Hospital would gain by a reduction in interest expense, and at the same time receive a windfall from Medicare for an "accounting loss" or "paper loss." *See* M. Fr. Pet. at 7 ("accounting loss"); Appellee's 5th Cir. Br. at 2 ("paper loss"). The Hospital's annual interest expense would be lower after the refinancing due to lower interest rates, but Medicare would share fully, dollar for dollar, in those savings because Medicare would reimburse the hospital based on those lower interest payments. The loss on defeasance, however, was a loss incurred in fiscal year 1987 to defease or extinguish its liability on the old bonds. The uncontradicted record testimony was that this was not a paper loss, but a real loss. Admin. Rec. 453-54, 457 (Valorz).[4]

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[4] The Secretary apparently seeks to create some confusion regarding the amount of the loss. M. Fr. Pet. at 8. There should be no doubt about this issue. The PRRB's decision did not determine the size of the loss, even though the Hospital submitted figures showing the dollar amount of the loss ($11,671,393) and the estimated reimbursement impact ($4,565,362). Admin. Rec. 1012. The loss figure was taken from

REASONS FOR DENYING THE PETITION

I. There Is No Conflict Among The Circuits On The GAAP Question.

The arguments advanced in the *Guernsey* Petition for granting certiorari are seriously flawed. Mother Frances Hospital therefore believes that certiorari should not be granted in the instant case, and respectfully suggests that the Petition in *Guernsey* may have been improvidently granted based upon allegations of a conflict among the circuits when such a conflict simply does not exist.

Both *Guernsey* and *Mother Frances* are "advance refunding" or "loss on defeasance" cases. The ultimate issue in each case is whether a loss on defeasance of debt should be reimbursed by Medicare in the year in which the defeasance occurred or whether it should be amortized over a future period of years.

All extant Court of Appeals decisions and District Court decisions in these "loss on defeasance" cases are in complete accord and have reached the identical result. The case law is unanimous. In every case presenting this ultimate issue, the courts have held that the provider is entitled under applicable Medicare statutes and regulations to receive reimbursement in the year of defeasance. There is not even arguably any conflict among circuits, or

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the Intermediary's own workpaper furnished by the Intermediary to the Hospital. In the District Court, counsel for the Secretary refused to admit the validity of the size of the loss calculated by the Intermediary, shown on the Intermediary's own workpaper, and given to the Hospital. In any event, the size of the loss and the reimbursement impact can be calculated on remand should the Hospital prevail, as the Fifth Circuit directed. M. Fr. Pet. at 10a.

among district courts, as to the proper result in these cases. These cases are:

Courts of Appeals

Guernsey Memorial Hosp. v. Secretary of HHS, 996 F.2d 830 (6th Cir. 1993), *cert. granted*, 114 S. Ct. 1395 (1994); *Mother Frances Hosp. of Tyler, Texas v. Shalala*, 15 F.3d 423 (5th Cir. 1994), *petition for cert. filed* (May 31, 1994).

District Courts

Methodist-Evangelical Hosp., Inc. v. Shalala, Medicare & Medicaid Guide (CCH) ¶ 42,017 (D.D.C. Dec. 22, 1993); *St. John's Hosp. v. Shalala*, Medicare & Medicaid Guide (CCH) ¶ 41,700 (E.D. Mich. Aug. 18, 1993); *Graham Hosp. Ass'n v. Sullivan*, 832 F. Supp. 1235 (C.D. Ill. 1993); *Mercy Hosp. v. Sullivan*, Medicare & Medicaid Guide (CCH) ¶ 40,227 (D. Me. 1991); *Baptist Hosp. East v. Sullivan*, 767 F. Supp. 139 (W.D. Ky. 1991); *Ravenswood Hosp. Medical Center v. Schweiker*, 622 F. Supp. 338 (N.D. Ill. 1985).

To attempt to create a conflict where none exists, the Secretary has endeavored to recast the issue in extremely broad terms, and to bring in other cases that are not "loss on defeasance" cases but have presented other issues under some of the same regulations involved in this case. Thus, she characterizes the question as "whether the Secretary and fiscal intermediaries are required to follow GAAP," Guern. Pet. at 11, and "[w]hether [the regulations] require that provider costs be reimbursed according to 'generally accepted accounting principles . . . .'". M. Fr. Pet. at I.

But the Courts of Appeals and District Courts have not painted with such a broad brush. Even if it were necessary or appropriate for this Court to grant certiorari to consider an alleged conflict that is not present in the line of cases of which this case is a part, the decisions

cited by the Secretary in the *Guernsey* Petition do not conflict with each other. They can be reconciled by using precisely the analysis employed by the Fifth Circuit Court of Appeals in the *Mother Frances* case; namely, that §§ 413.20(a) and 413.24 are not necessarily used to determine which costs are "allowable" for Medicare reimbursement but are properly used to determine accounting issues, such as timing, for costs that are "allowable."

The Secretary lists the following ten cases as standing for the proposition that 42 C.F.R. §§ 413.20 and 413.24 "mandate the use of GAAP to determine allowable costs, unless the Secretary has promulgated a more specific regulation dealing with a particular cost issue" (Guern. Pet. at 11):[5]

Courts of Appeals

Guernsey Memorial Hosp. v. Secretary of HHS, 996 F.2d 830 (6th Cir. 1993), *cert. granted*, 114 S. Ct. 1395 (1994); *HCA Health Services of Midwest, Inc. v. Bowen*, 869 F.2d 1179 (9th Cir. 1989); *Charlotte Memorial Hosp. & Medical Center, Inc. v. Bowen*, 860 F.2d 595 (4th Cir. 1988); *National Medical Enterprises v. Bowen*, 851 F.2d 291 (9th Cir. 1988); *Villa View Community Hosp., Inc. v. Heckler*, 720 F.2d 1086 (9th Cir. 1983).

District Courts[6]

Methodist-Evangelical Hosp., Inc. v. Shalala, Medicare & Medicaid Guide (CCH) ¶ 42,017 (D.D.C. Dec. 22, 1993); *Graham Hosp. Ass'n v. Sullivan*, 832 F. Supp. 1235 (C.D. Ill.

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[5] The Secretary did not include the *Mother Frances* case, because the decision in that case was rendered by the Fifth Circuit after the Petition in *Guernsey* was filed. Presumably, she would align it with *Guernsey*.

[6] The Secretary omits *St. John's Hosp. v. Shalala*, Medicare & Medicaid Guide (CCH) ¶ 41,700 (E.D. Mich. Aug. 18, 1993).

1993); *Mercy Hosp. v. Sullivan*, Medicare & Medicaid Guide (CCH) ¶ 40,227 (D. Me. 1991); *Baptist Hosp. East v. Sullivan*, 767 F. Supp. 139 (W.D. Ky. 1991); *Ravenswood Hosp. Medical Ctr. v. Schweiker*, 622 F. Supp. 338 (N.D. Ill. 1985).

The only cases which allegedly establish a different rule, according to the Secretary, are as follows:[7]

Courts of Appeals

Sun Towers, Inc. v. Heckler, 725 F.2d 315 (5th Cir.), *cert. denied*, 469 U.S. 823 (1984); *National Medical Enterprises v. Sullivan*, 916 F.2d 542 (9th Cir. 1990), *cert. denied*, 500 U.S. 917 (1991); *North Clackamas Community Hosp. v. Harris*, 664 F.2d 701 (9th Cir. 1980).

District Courts

American Medical Int'l, Inc. v. Secretary of HEW, 466 F. Supp. 605 (D.D.C. 1979), *aff'd*, 677 F.2d 118 (D.C. Cir. 1981); *Queen's Medical Center v. Sullivan*, 797 F. Supp. 821 (D. Haw. 1991).

Court of Claims

Methodist Hospital of Indiana, Inc. v. United States, 626 F.2d 823 (Ct. Cl. 1980).

None of these cases establishes a rule that differs from that applied in *Mother Frances* or *Guernsey*.

To see why this is so, the law in the Fifth Circuit is the most instructive. The principal case cited by the Secretary to show a supposed conflict is *Sun Towers*, which quoted from and relied upon *American Medical* in its holding. What the Secretary's argument overlooks, however, is that the "stock

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[7] The Secretary also cites *Richey Manor, Inc. v. Schweiker*, 684 F.2d 130 (D.C. Cir. 1982), but notes that any such expression of a different rule was dictum.

maintenance" cost cases, such as *Sun Towers* and *American Medical*, have to do with whether § 413.20(a) is to be used to determine "costs *allowable*" under the Medicare program; that is, "*reimbursable* costs." *Sun Towers*, 725 F.2d at 329, *citing American Medical*, 466 F. Supp. at 623. (emphasis added) "Allowable costs" is a term of art, and means whether the costs are of the kind for which Medicare will reimburse providers. To be allowable, costs must be related to patient care. 42 C.F.R. § 413.9(c)(3). In *Sun Towers*, the Court noted that the Secretary had found that "these costs were not related to actual patient care or necessary to the rendition of patient care services. Therefore, she concluded, these costs could not properly [be reimbursed]." *Sun Towers*, 725 F.2d at 326.

But the *Mother Frances* and *Guernsey* cases are not about whether the loss on defeasance is an "allowable," reimbursable cost under Medicare. The loss is admittedly a reimbursable cost.[8]

Instead, the question presented by loss on defeasance cases such as *Mother Frances* and *Guernsey* is simply an accounting question: in what year should the admittedly allowable cost be recognized? It is solely a question of timing.

After noting that *Sun Towers* is not contrary to its decision in *Mother Frances*, the Fifth Circuit explained exactly why there is no conflict:

> In *Sun Towers*, this Court was called on to decide whether certain costs were allowable under the Medicare program. Among these costs were

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[8] The Secretary explicitly so stated in her summary judgment brief filed in the District Court in this case: "There is no dispute that the 'loss' represents costs which are reimbursable under the Medicare program. Instead the dispute concerns the time period over which the hospital may be reimbursed for this loss." Def. Summ. J. Br. at 7.

"stock maintenance costs." The Secretary disallowed reimbursement for these costs finding that they were only tangentially related to the care of Medicare beneficiaries. The district court, however, reversed the Secretary's determination.

Among the arguments the district court presented to support its decision in *Sun Towers* was an argument based on GAAP. Under GAAP, stock maintenance costs are recognized as general and administrative expenses. Thus, the district court argued that these costs were allowable because 42 C.F.R. § 405.406 [the predecessor to § 413.20] required GAAP to be applied in determining reasonable costs.

We rejected this argument holding that GAAP was not necessarily to be used in determining if a particular cost was allowable. In particular, we found that section 405.406 was not designed to determine the *"costs allowable* under the Medicare Act. The regulation is directed at the type of financial data and reports required of providers; it is not a regulation affecting the substantive provisions of the program as to *what constitutes reimbursable costs."* Hence, we reversed the decision of the district court and held that the Secretary's determination was neither arbitrary nor capricious.

In *Sun Towers,* the issue was *whether* a particular cost was allowable at all. In the case at bar, as it was in the *Guernsey* case, the issue is *when* a cost that was clearly allowable should have been reimbursed. These are different questions and we do not believe that *Sun Towers* speaks to the issue of *when* reimbursement is to be made.

> Accordingly, we adhere to our decision in *Sun Towers* as to *whether* a particular cost is allowable. However, we follow *Guernsey* as to *when* advance refunding costs are to be reimbursed.

M. Fr. Pet. at 9a-10a (all footnotes and citations omitted; emphasis by Fifth Circuit). The Fifth Circuit further stated in *Mother Frances* that *Guernsey* is "a case on all fours with the case *sub judice*," and that "[w]e agree with the reasoning of *Guernsey* and adopt its holding that the Medicare regulations provide for the use of GAAP in determining the timing of Medicare reimbursement in advance refunding transactions. . . . " M. Fr. Pet. at 8a.

There can thus be no conceivable conflict between *Sun Towers* and either *Guernsey* or *Mother Frances*, when the Fifth Circuit expressly reconciled its decision in *Sun Towers* with its decision in *Mother Frances* and with the *Guernsey* case.

The Secretary cites a District Court case from the District of Columbia, *American Medical*, as presenting a conflict. But *American Medical* was also distinguished by the District Court that decided it as presenting no conflict with the line of decisions in advance refunding cases. In *Methodist-Evangelical*, the United States District Court for the District of Columbia considered two consolidated advance refunding cases that had been brought by a total of seven hospitals. That court noted that the "issues here have been thoroughly and authoritatively resolved in the Sixth Circuit's opinion in *Guernsey*." *Methodist-Evangelical*, Medicare & Medicaid Guide (CCH) ¶ 42,017 at 38,788. It expressly distinguished *American Medical* (and *Richey Manor*) on grounds that "each of these cases determines reimbursability *vel non*; none addresses the timing of reimbursement. *Guernsey* teaches that GAAP governs reimbursement timing and is what is at issue here. The law of this Circuit does not compel an interpretation different from that in *Guernsey*." *Id.* at 38,789.

Turning to the Ninth Circuit, the principal case that the Secretary believes to have established a rule contrary to *Guernsey* and *Mother Frances* is *NME v. Sullivan*. But that case, too, like *Sun Towers* and *American Medical*, is a "stock maintenance" costs case. It is distinguishable on precisely the same basis that the Fifth Circuit and the District Court for the District of Columbia distinguished *Sun Towers* and *American Medical*.

The only other Ninth Circuit case cited by the Secretary as being in conflict with *Guernsey* and *Sun Towers* is *North Clackamas*. That case also dealt with whether certain costs were related to patient care, and thus whether they were "allowable," reimbursable costs. The issue in *North Clackamas* was whether certain intangible costs were reimbursable. The Court, per Kennedy, J., held that the costs were "not reimbursable." 664 F.2d at 707. *North Clackamas* is thus like *Sun Towers*, *American Medical*, and *NME v. Sullivan*, because the issue in that case was whether costs were "allowable" rather than how admittedly allowable costs ought to be treated under applicable accounting rules.[9]

This leaves only *Methodist Hospital of Indiana* as a case supposedly in conflict with *Guernsey* and *Mother Frances*. That case does not present a conflict for several reasons.

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[9] The Secretary also cites *Queens* as establishing a rule contrary to *Guernsey* and *Mother Frances*. Guern. Pet. at 13 n.8. But *Queens* is only a District Court case within the Ninth Circuit. As shown above, there is no conflict between the two Ninth Circuit cases cited by the Secretary, and *Guernsey* and *Mother Frances*. In addition, the question in *Queens* was whether certain malpractice costs were reimbursable at all. The Court noted that GAAP was not designed "for determining what health care costs are reasonable and should be *reimbursable* under Medicare." *Queens*, 797 F. Supp. at 826. Thus, its holding also does not conflict with *Mother Frances*.

- First, it does not even involve the application of § 413.20(a), the GAAP regulation. It deals only with accrual accounting issues.
- Second, like the cases cited above, the question in *Methodist Hospital of Indiana* was whether a cost was reimbursable at all. The Court held that a cost that was legally required to be paid but was not paid, could be determined not to have been "incurred" and thus not be reimbursable. *Methodist Hospital of Indiana*, 626 F.2d at 827.
- Third, the Court of Claims in this 1980 decision had jurisdiction only because the statutory procedure which established the PRRB and the present administrative and judicial mechanisms for review of provider disputes was not yet in effect for the cost year at issue. The mechanisms established by 42 U.S.C. § 1395oo are effective only for provider cost reports ending on or after June 30, 1973. *See* Pub. L. 92-603, § 243, 1972 U.S.Code Cong. & Admin. News (92 Stat.) 1661-63. The dispute in *Methodist Hospital of Indiana* was for the hospital's fiscal year ended February 28, 1969. Jurisdiction for judicial review of PRRB and Administrator's decisions is now vested exclusively in the federal District Courts, not the Court of Federal Claims. 42 U.S.C. § 1395oo(f). Thus, even if *Methodist Hospital of Indiana* established some rule that was in conflict with *Guernsey* and *Mother Frances* – which it did not – any such conflict would be essentially irrelevant at present.

Thus, to attempt to show a conflict, the Secretary has stated the "question presented" in an overly broad manner.[10] The advance refunding cases are unanimous. But even when

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[10] The "question presented" is also phrased in a circular fashion by the Secretary. By describing §§ 413.20(a) and 413.24 as "general Medicare record-keeping and reporting regulations" the Secretary has attempted to insert her answer to the question into the question itself.

the broader question is examined, the cases are reconcilable on the basis expressed in *Mother Frances.*

The Petition should also be denied because the Secretary is now arguing in this Court a considerably different case than was argued below. Her arguments contradict the positions that she has taken in prior stages of this case and elsewhere.

For example, a question considered in the proceedings below was whether § 413.20(a) deals with reimbursement under GAAP because it was meant to implement the language of 42 U.S.C. § 1395x(v)(1)(A). That statute requires that "In prescribing the regulations [to determine reasonable costs], the Secretary shall consider . . . the principles applied by national organizations or established prepayment organizations . . . in computing the amount of payment . . . to providers of services . . . . "

At page 21 of the *Guernsey* brief on the merits, the Secretary now argues that "[t]he available evidence thus confirms what is in any event the natural reading of the statutory language: that the 'principles . . . applied by national organizations or established prepayment organizations' that the statute requires the Secretary to 'consider' have nothing specifically to do with GAAP." However, that position directly contradicts the Secretary's administrative decision in this case. In a discussion of GAAP principles, the following statement appears in the Administrator's decision:

> Section 1861(v)(1)(A) of the Act only required the secretary to "consider . . . the principles generally applied by national organizations." The Secretary is not required to adopt them for determining reimbursable costs. [*citing* three cases, including *Sun Towers* and *American Medical*]. Neither Congress nor the Secretary abdicated to the accounting profession the responsibility for determining Medicare reimbursement policy. Moreover, the Foreword to the PRM indicates that GAAP should be

> followed only in the absence of specific guidelines and instructions in the PRM. [footnote omitted]

M. Fr. Pet. at 50a. As is evident from this passage in the *decision under review in this case*, the Secretary entertained no doubt that the statutory language relating to "principles generally applied by national organizations" referred to GAAP. Now, the Secretary urges this Court to adopt the opposite position on a fundamental issue expressly treated in the Administrator's decision.

Similarly, the Secretary seeks to argue a different case in this Court than it did in the lower courts with respect to the effect of 42 U.S.C. § 413.20(a). Below, the Secretary merely sought to argue that § 413.20(a) is not a payment or reimbursement provision, but relates to recordkeeping only. Now, in this Court, the Secretary argues in the *Guernsey* case that § 413.20(a) does not even *refer* to GAAP or relate to GAAP in any way:

> In any event, Section 413.20(a) by its terms does not require use of GAAP. It refers only to practices standard "in the hospital and related fields," suggesting if anything the use of "specially" rather than "generally" accepted principles.

Guern. Pet. at 19. In both the Court of Appeals and the District Court in this case, the Secretary explicitly admitted and argued that § 413.20(a) referred to GAAP (although contending that it did not govern payment or reimbursement). In the Fifth Circuit, the Secretary argued that the language of § 413.20:

> [I]nforms providers that they need not "change" their "standard accounting practices" in order to participate in the Medicare program. It does *not* direct that all costs found by such "standard practices" will be reimbursed. Such an approach would improperly transfer the authority to determine what costs are reimbursable under Medicare from the Secretary to the American Institute of Certified

> Public Accountants ("AICPA"), which promulgates GAAP. (emphasis in original)

Appellees' 5th Cir. Br. at 20. The Secretary stated in that same brief, at 21, that by the provisions of § 413.20(a) "the Secretary did not mandate that a provider's 'standard practices' in keeping its accounting books and records (which is, after all, what GAAP is) should govern the amount of reimbursement payable under the program."

In other cases, contrary to the position argued by the Secretary below, the Secretary has taken the position that the GAAP provisions of § 413.20(a) require *reimbursement* (not mere recordkeeping) in accordance with GAAP. *See* cases cited in Amicus Br. of AHA at 14-16.

Thus, the Hospital believes that it is unnecessary and inappropriate to grant certiorari in this case to afford the Secretary the opportunity to establish legal propositions that are directly contrary to positions she has adopted in other cases, and, indeed, in this very case.

II. The Rulemaking Question Furnishes No Basis For Granting Certiorari.

The Secretary does not claim in the Guernsey Petition that there is any conflict among the circuits on the rulemaking issue. Indeed, all courts that have considered the rulemaking issue in this context have held that PRM § 233 is invalid as a substantive rule. There is no asserted conflict as to the legal standard to be applied on this issue. Thus, the rulemaking question presents no special reason for granting the petition in either the *Mother Frances* or *Guernsey* cases.

It is important to clarify the relationship of the GAAP argument to the rulemaking argument. The Secretary claims that the Court's conclusion that § 233 is an invalid substantive rule would have "no force independent of the court's determination that the Manual provision . . . conflicts with a GAAP accounting requirement embodied in

Sections 413.20 and 413.24 of the regulations . . . . " Guern. Pet. at 22. Mother Frances Hospital expressly argued before the Fifth Circuit that the "rulemaking arguments urged throughout this brief are logically independent of the GAAP and accrual accounting arguments" set forth therein. Appellant's 5th Cir. Br. at 27. The brief continued: "If it is true that 42 C.F.R. § 413.20 requires GAAP to be followed in determining reimbursement, as the *Guernsey* court held and as argued below, PRM § 233 unquestionably represents a change from that regulatory requirement. But even if 42 C.F.R. § 413.20 did not require GAAP to be followed, PRM § 233 is still a substantive rule . . . . " *Id.*

This rulemaking argument was set forth explicitly as Count II of the Complaint, and was briefed as an independent argument in the District Court and the Fifth Circuit. Pl. Summ. J. Br. at 26-33; Appellant's 5th Cir. Br. at 19-31.

There is an important shift between the Secretary's position in the Guernsey Petition, and in the brief on the merits submitted by the Secretary in that case. In the Guernsey Petition, the cited case law discussed only the definitions of "substantive" as opposed to "interpretative" rules. Guern. Pet. at 23. The Secretary then argued that "Section 233 of the PRM is plainly an interpretative rule." *Id.* Although the Petition mentioned that "statements of policy" could be exempted from APA notice and comment requirements, *id.*, the Secretary did not argue that § 233 constituted a "general statement of policy." In the Secretary's brief on the merits, however, she now argues that PRM § 233 is a "general statement of policy." Guern. Pet. Br. at 35.

The argument that § 233 is a "general statement of policy" was never advanced by the Administrator in his decision, by the Secretary in the District Court in *Mother Frances*, or by the Secretary in the Fifth Circuit. Counsel for Mother Frances is informed that it was not argued in the Sixth Circuit in *Guernsey*. It is a new argument, advanced for

the first time in this Court, after the Petition was granted. Case law demonstrating that PRM § 233 cannot be considered a "general statement of policy" is contained in the Mother Frances Amicus Brief at 19.

The Secretary contends that certiorari should be granted in this case because "an agency's interpretation of its own regulations should be given 'controlling weight' unless it is plainly erroneous or inconsistent with the language of the regulation." Guern. Pet. at 26. She complains of "judicial misinterpretation" of her regulations. *Id.*

As is clear from the history of the *Mother Frances* case, however, the Secretary has been at a loss even to identify the regulations of which PRM § 233 is allegedly interpretative.

The Administrator's decision identified only one regulation of which PRM § 233 was supposedly interpretative. That regulation is 42 C.F.R. § 413.9(b)(1). The Administrator's decision asserts that § 233 "is interpretative of 42 C.F.R. 413.9" which, according to the Administrator, "requires payments to be based on 'the actual cost of services rendered to beneficiaries during the year.'" M. Fr. Pet. at 49a.[11] As shown at length in the Mother Frances Amicus Brief at 12-15, § 413.9(b)(1) has nothing to do with the issues in this case. The argument by the Administrator depends entirely upon quoting a small portion of that regulation out of context. The regulation does not pertain to attribution of costs to particular years. Instead, § 413.9(b)(1) deals with retroactive adjustments, which are used simply to reconcile the final cost amount shown in the Medicare cost report to the amounts paid on an interim basis during the year.

In the District Court, the Secretary specifically claimed, at several places in her brief, that PRM § 233 was interpretative of § 413.9(b)(1). For example, the Secretary argued that

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[11] The Administrator cites the regulation as 42 C.F.R. § 413.9, but the portion quoted is from § 413.9(b)(1).

" . . . PRM § 233 is interpretive of defendant's policy that a Medicare provider will be reimbursed only for the actual cost of providing services to beneficiaries during the year as required by 42 C.F.R. § 413.9(b)(1)." Def. Summ. J. Br. at 28-29.[12]

In the Fifth Circuit Court of Appeals, the Hospital in its opening brief demonstrated that § 413.9(b)(1) has nothing to do with apportionment of costs *among years*, by an argument similar to that set out in the Mother Frances Amicus Brief at 12-15. The Secretary responded by listing a series of five *different* regulations of which PRM § 233 is allegedly interpretative, while § 413.9(b)(1) disappeared from that list. *See* Appellees' 5th Cir. Br. at 38. Those regulations were:

- 42 C.F.R. § 413.5(b)(6)
- 42 C.F.R. § 413.9(b)(2) with a "see generally" citation to "Subpart G."
- 42 C.F.R. § 413.130(a)(10)
- 42 C.F.R. § 413.153(a)(1) and (b)(1)
- 42 C.F.R. §§ 413.5(a) and 413.9[13]

In the Fifth Circuit, the Hospital pointed out that 42 C.F.R. § 413.130(a)(10) was not promulgated until more than

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[12] *See also id.* at 2 (" . . . PRM § 233 properly interprets the regulation requiring that a provider be reimbursed only for the actual cost of health care services furnished to Medicare beneficiaries during the year. *See* 42 C.F.R. § 413.9(b)(1)"); *id.* at 5 ("Medicare payments in a given cost year must be based on the 'actual cost *of services* furnished to beneficiaries *during the year*.' 42 C.F.R. § 413.9(b)(1)." (emphasis in Def. Br.))

[13] 42 C.F.R. §§ 413.5(a) and 413.9 were cited for the proposition that "regulations require that reimbursable costs be related to Medicare patient care." Appellees' 5th Cir. Br. at 38. The subsection of 413.9 that stands for that proposition is 42 C.F.R. § 413.9(c)(3), which confirms that "amounts not related to patient care" are not "allowable," that is, are not reimbursable costs.

eight years after PRM § 233 became effective. *See* Amicus Br. of M. Fr. Hosp. at 16. In this Court, the Secretary now cites a group of regulations similar to those relied upon in the Fifth Circuit, although 42 C.F.R. § 413.130(a)(10) has been dropped, and two different regulations (42 C.F.R. §§ 413.130(a)(7) and (g)) have been added. 42 C.F.R. § 413.5(b)(6) was dropped as well. A reference to the Administrator's reliance on 413.9(b)(1) has also reappeared. Pet. Br. at 39.

Arguments showing that PRM § 233 is not interpretative of any of these regulations were set forth at pages 12-19 of the Amicus Brief of Mother Frances Hospital, and will not be repeated here. The two newly added regulations, however, deserve special mention. In addition to arguing that §§ 413.130(a)(7) and (g) add nothing to the analysis in this case, Mother Frances pointed out that those two subsections were *also* published after PRM § 233 was issued. Amicus Br. of M. Fr. Hosp. at 16. Sections 413.130(a)(7) and (g) were not published as an interim final rule until September 1, 1983. *See* 48 Fed. Reg. 39752, 39809, 39810 (Sept. 1, 1983). This was approximately four months after the issuance of PRM § 233, and two months after its effective date. *See* Amicus Br. of M. Fr. Hosp. at 16-17.

In her reply brief in the *Guernsey* case, the Secretary responded that the September 1, 1983 *Federal Register* notice publishing 42 C.F.R. §§ 413.130(a)(7) and (g) "merely reorganized and clarified the preexisting regulations that had authorized reimbursement of capital-related costs, such as interest and 'other costs related to . . . capital expenditures.' *See* 42 C.F.R. 405.402(c), 405.419, 405.435 (1982)."[14] Guern. Pet. Reply Br. at 9 n.5.

The September 1, 1983, *Federal Register* notice did nothing of the kind.

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[14] At the time of publication of the notice, what is now 42 C.F.R. § 413.130 was originally codified as 42 C.F.R. § 405.414.

Section 405.419, designated as "Interest expense," is merely the predecessor to § 413.153, the current interest regulation. The September 1, 1983 *Federal Register* notice did not amend, change, or reorganize § 405.419 in any fashion.

Section 405.435, captioned "Nonallowable costs related to certain capital expenditures," related to state capital expenditure review activities under Section 1122 of the Social Security Act. Section 1122 created a voluntary capital expenditure review program in which states could participate, and is not relevant to the issues in this appeal. This section was not changed or amended by the September 1 *Federal Register* notice.

Section 405.402(c) was misquoted by the Secretary. She contends in her Reply Brief that § 405.402(c) authorized reimbursement for "other costs related to . . . capital expenditures." Guern. Pet. Reply Br. at 9 n.5. However, the relevant text of 405.402(c), after discussing certain items under the principles of reimbursement, stated as follows:

> However, costs such as depreciation, interest on borrowed funds, a return on equity capital (in the case of proprietary providers), and other costs related to certain capital expenditures are subject to the provisions of § 405.435, "Nonallowable costs related to certain capital expenditures."

In other words, § 405.402(c) did not "authorize reimbursement" of capital expenditures as the Secretary asserts, but merely noted that certain capital expenditures were subject to the Section 1122 state review program as referenced in § 405.435, discussed above.

Plainly, the September 1, 1983, *Federal Register* notice did not "reorganize" or "clarify" any of these regulations. That fact can be easily ascertained by examining the text of § 405.414 in the September 1, 1983 notice, beginning at 48 Fed. Reg. 39809. Similarly, a comparison of the 1982 and 1983 editions of the Code of Federal Regulations reveals that all

three regulations cited by the Secretary as being "reorganized or clarified" by § 405.414 were unaffected by that new regulation.

The Secretary's complaints about the alleged "disregard" by the Court of Appeals of her interpretation of her own regulations, Guern. Pet. at 26, are seriously undermined by her shifts in position as to which regulations § 233 allegedly interprets, and her continued miscitation of regulations that were not even in effect at the time § 233 was issued.

III. The Substantial Evidence Question Does Not Justify Granting The Petition.

Because the Secretary did not include a "substantial evidence" issue in the "Questions Presented" in this case, there would appear to be no reason to grant certiorari based on that issue.

As noted above, the Hospital has presented a "substantial evidence" challenge to the decision of the Administrator throughout this lawsuit.[15] Count I of the Hospital's Complaint stated that "The Decision and the findings and conclusions therein are unlawful and should be set aside pursuant to 5 U.S.C. § 706 because they are arbitrary, capricious, an abuse of discretion or otherwise not in accordance with law; are [in violation of other APA provisions]; and are unsupported by substantial evidence."

The substantial evidence argument was presented to the District Court in the Hospital's brief. *See* Pl. Summ. J. Br. at

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[15] Mother Frances Hospital is not attempting to distance itself from the *Guernsey* case by outlining the substantial evidence issue. The Hospital believes that in neither case is the Administrator's decision supported by substantial evidence. The evidence has been summarized here briefly to acquaint the Court with this issue for purposes of making an accurate procedural disposition of the case.

13 (citing substantial evidence test and cases); and 22-26 (discussing and citing testimony in the record). It was also explicitly briefed in the Fifth Circuit, as Issue No. 3 in the "Statement of the Issues". Appellant's 5th Cir. Br. at 3. This issue was not discussed by the Fifth Circuit in its opinion, presumably because the resolution of the first two issues (the GAAP and the rulemaking issues) in favor of Mother Frances Hospital made consideration of the substantial evidence issue unnecessary.

The record in the Mother Frances case consisted of stipulated testimony by four witnesses from three other cases. The three cases were *Guernsey*, *St. John's*, and *Mercy*. The testimony of expert witness Douglas Langenfeld on behalf of the provider in *Guernsey* was included in the record in Mother Frances, and is, of course, part of the record in *Guernsey*. Expert testimony on behalf of the provider in *St. John's* and *Mercy*, by John Valorz and Chris Corrie, also was stipulated as part of the *Mother Frances* record. Stipulated testimony on behalf of the intermediary was provided by Wilson Leong, from the *St. John's* case.

Some of the "substantial evidence" in the *Guernsey* case was set forth in the amicus brief filed by Mother Frances Hospital in that case. Amicus Br. of M. Fr. Hosp. at 26-28. This evidence is pertinent to the Administrator's finding that the loss on defeasance in "economic reality" relates to future years after the defeasance. The evidence in the *Mother Frances* record included the following:

- No cost is incurred by the provider in periods after the refunding. Admin. Rec. 467-68 (Valorz); 679, 705 (Leong).
- "There is no future interest cost to the provider" after defeasance. Admin. Rec. 703 (Leong).
- The loss on defeasance does not relate to any future period. Admin. Rec. 559-60, 578 (Langenfeld).
- No future costs related to the defeasance are reflected on the provider's books, such costs are not a liability of the

provider, and interest costs are not being incurred on the old debt by the provider in future years. Admin. Rec. 703, 705 (Leong).

- Providers are no longer liable for repayment of the old debt after an advance refunding transaction. Admin. Rec. 467, 473 (Valorz); 506-07, 516 (Langenfeld); 595-96 (Corrie); 690 (Leong).
- The provider no longer makes any payment relating to the refunded debt after the defeasance. Admin. Rec. 669 (Leong).
- The old debt ceases to exist for hospital purposes following a refunding. Admin. Rec. 506, 514 (Langenfeld).
- If the loss on defeasance is related to any year other than the year in which it was incurred, the loss relates to past periods and not future periods. Admin. Rec. 504 (Langenfeld); 603-04 (Corrie).
- The loss on advance refunding is a belated recognition of past costs upon extinguishment of the old bonds, specifically, the difference between the net carrying cost of the old bonds and the price necessary to reacquire the bonds. Admin. Rec. 499, 505, 510-11 (Langenfeld); 603-04, 611 (Corrie).
- Mr. Leong, the Intermediary's own witness, testified that he would look to GAAP [rather than 42 C.F.R. § 413.153, the interest regulation] in considering the timing of reimbursement. Admin. Rec. 663 (Leong).
- After contending that "the actuality of the situation is the debt has not been liquidated," Mr. Leong admitted that there is no basis in regulation for this assertion. Admin. Rec. 672 (Leong).

This testimony thus served to show that the "economic reality" argument – in which the loss on defeasance is said to relate to future years – had absolutely no basis in the administrative record. Similarly, the "cross-subsidization" argument advanced by the Administrator depends upon a finding that costs are attributable "in economic reality" to

future years, M. Fr. Pet. at 49a, 54a, a proposition that is overwhelmingly refuted by the administrative record.

In the *Guernsey* appeal, the Secretary admits that the issue of the periods to which the loss on defeasance relates is a factual matter. *See* Guernsey Br. at 16 ("[t]he Secretary's conclusion that the costs at issue here must be apportioned over several periods is entirely justified, both as a programmatic and as a factual matter . . . "); *id.* at 35 ("[b]oth as a programmatic matter for Medicare reimbursement determinations and as a factual matter in this case, the Secretary's conclusion that respondent's 'loss' on defeasance relates to more than one accounting period [is allegedly justified]"). In the *Mother Frances* case, the Administrator's decision did not cite to testimony of record to support the secretary's "economic reality" contention. In neither the District Court nor the Court of Appeals did the Secretary undertake to support the findings in the Administrator's decision by making a substantial evidence argument based upon citations to the record.[16]

CONCLUSION

There is no conflict among the circuits or other reason that would make it necessary to grant certiorari in this case.[17] Accordingly, certiorari should be denied in *Mother*

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[16] A few citations to the record appeared in the briefing before the District Court and Court of Appeals, but never as part of a substantial evidence argument advanced by the Secretary.

[17] The advance refunding issue is unlikely to be of "continuing importance," as the Secretary asserts. Guern. Pet. at 25, n.14. Because of the transition to the capital PPS system, Guern. Pet. at 4, n.1, only a small percentage of hospitals or their facilities are being reimbursed on a "reasonable cost" basis after October 1, 1991. These consist principally of psychiatric,

Frances, and the Hospital respectfully suggests that certiorari may have been improvidently granted in *Guernsey* as well.

Should the Court decide *Guernsey* on its merits, the Hospital believes that the following dispositions would be appropriate for the instant case. If the Court finds in favor of Guernsey Memorial Hospital on either of the two questions expressly presented in that case (the GAAP issue or the rulemaking issue) and thus affirms the Sixth Circuit's *Guernsey* decision, the instant case would be governed by such rulings and certiorari should be denied in this case. If the Court finds against Guernsey Memorial Hospital on both issues, certiorari should be granted in the instant case and the case should be remanded to the Fifth Circuit for further consideration in light of *Guernsey*, with leave for the lower courts to consider the substantial evidence issue. Should the Court reach the substantial evidence issue in *Guernsey*, the Hospital also believes that granting certiorari and remanding the *Mother Frances* case would be appropriate due to the fact

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rehabilitation, and long term care facilities. 42 C.F.R. §§ 412.22-412.30. Thus, for general acute care hospitals, losses from advance refundings would rarely be appealed for cost years after 1990. Cost reports must normally be settled within fifteen months after the close of the hospital's fiscal year. *See* 42 C.F.R. § 413.24(f)(2); PRM § 2905.1. Therefore, most of the appeals likely to raise this issue have already been filed, and many of them have been resolved. Instead of bringing certainty to an uncertain area, granting of certiorari and reversal of *Mother Frances* and *Guernsey* would disrupt the unanimous line of decisions on advance refundings and cause determinations in favor of dozens of hospitals to be overturned. *See* Amicus Br. of Hospitals Participating in *St. John Hospital et al. v. Shalala*, 1-4 (28 hospitals in *St. John* appeal alone). Such a result is undesirable when new advance refunding cases are unlikely to arise to any significant extent in the future, most of the cases have either been decided or are well into the process of appeal and judicial review, and the lower courts are unanimous in their treatment of these cases.

that there are different administrative records in the two cases.

Respectfully submitted,

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